

2 month – well child care

Name: _____

Please circle either yes or no as it pertains to your child

Household

Who lives in the home (e.g. Father, mother, brother, etc.)? _____

Does your child attend daycare? Yes No

Development

Holds head steady when held Yes No

While on stomach lifts head/chest 20 degrees Yes No

Follows object with eyes Yes No

Holds objects put in hands Yes No

Alerts to sound Yes No

Reacts to the sight of bottle or breast Yes No

Coos Yes No

Smiles Yes No

Recognizes primary care giver Yes No

Nutrition

How is the baby fed? (circle one) Breast Fed Formula Fed

If Formula Fed, what is the name of the formula? _____

How much and how frequent? _____

If breastfeeding, is the child on a
vitamin D supplement (e.g. trivisol)? Yes No

Wakes for feeds overnight? Yes No

Bowel habits

How many stools a day?

What do the stools look like (soft, seedy, loose)? _____

Sleep Pattern

Sleeps on back? Yes No

How many hours a day? _____

Safety

Is car seat in the back seat and rear facing? Yes No

Is your child exposed to tobacco smoke? Yes No

Are there any improperly stored
firearms in the home? Yes No

Is the hot water temperature set low enough
to prevent accidental burns? Yes No

Are there working smoke detectors in the home? Yes No

Miscellaneous

Who cares for the child at home most of the time? _____

Who else helps you care for your baby? _____

Any concerns about your child? Yes No

If yes, what are they?

Please circle any of the questions below to which your answer is “YES”.

Lead Risk Assessment:

- Lives in or regularly visits a house/building built before 1978 with peeling or chipping paint, recent/ongoing renovation or remodeling?
- Ever lived outside the United States or recently arrived from a foreign country?
- Sibling, housemate/playmate being followed or treated for lead poisoning?
- If born before 1/1/2015, lives in a 2004 “at-risk” zip code?
- Frequently puts things in his/her mouth such as toys, jewelry, or keys, eats non-food items?
- Contact with an adult whose job or hobby involves exposure to lead?
- Lives near an active lead smelter, battery recycling plant, other lead-related industry, or road where soil and dust may be contaminated with lead.
- Uses products from other countries such as health remedies, spices, or food, or store or serve food in leaded crystal pottery or pewter?

Tuberculosis Risk Assessment:

- Was your child born in, or lived more than a year in a country other than the U.S.?
- Has your child been exposed to anyone with either active or a history of Tuberculosis disease?
- Is your child living in a house hold with anyone who is HIV Positive?
- Is your child part of a migrant worker family?

Below this line is for Office Use:

Weight _____

Height _____

Head Circumference _____

Blood Pressure _____

Vision Test: Left 20/ ____ Right 20/ ____

Hearing Test: